CONSENT FOR DISCLOSURE OF INFORMATION

State Form 42224 (R8 / 1-97) / VRS 0014

I hereby give my consent to:
to disclose the following information

to the Division of Disability, Aging, and Rehabilitative Services. The information requested will be used only to assist in the administration of the habilitation/rehabilitation program(s) for the individual named below. All such information will be held to be confidential, and shall not be disclosed, other than in the administration of the individual's habilitation/rehabilitation program(s), except by the written consent of the individual named below and, as applicable, his or her parent, guardian, or other person authorized to sign in lieu of the individual, or as otherwise required by law.

If the information requested concerns drug or alcohol services, federal law forbids any use of this information to investigate or prosecute the individual.

This consent may be revoked at any time, except to the extent that the program which is to make the disclosure has already acted in reliance on it. If not revoked, the consent will expire 12 months (*60 days if the consent is for the release of medical records*) from the date signed, below, or upon a determination that the individual is ineligible or no longer eligible for services.

Signature of DDARS applicant/client:	Date (*month, day, year*)
Printed/typed name and address of DDARS applicant/client:	
(*If applicable*) signature of parent, guardian, or other authorized individual:	Date (*month, day, year*)
Printed or typed name of parent, guardian, or other authorized individual:	
Signature of Division of Disability, Aging and Rehabilitative Services representative:	Date (*month, day, year*)
Please forward the information listed above to:	

DISTRIBUTION: White - Vendor; Canary - Vendor; Pink - Client case file